This form may be completed online, printed and mailed to the address listed below.

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
CREDENTIALING DIVISION
P.O. Box 94986
Lincoln, Nebraska 68509-4986

APPLICATION FOR REGISTRATION AS A COMMUNICATION ASSISTANT

SECTION A - Personal Information (All applicants for registration must complete this section.)				
1	Name:			
2	Present Address	Street/Box/Route:		
		City:	State:	Zip:
3	Home Telephone – Optional:			
4	Social Security Number:			
5	Date of Birth:		Place of Birth:	
6	**Moral Character:**			
	a	Have you been convicted of a misdemeanor or felony other than a minor traffic violation? **Answer Yes or No**		
	b	Has your license in any health care profession in another state been revoked, suspended, limited or disciplined in any manner? **Answer Yes or No**		

If you answered **YES** to the above, you must request the following documents be sent directly to this office:

- Official Court Record, which includes charges and disposition
- If the conviction involved a drug and/or alcohol related offense, all addiction/mental health evaluations and proof of treatment (if treatment was obtained and/or required)
- If you are currently on probation, a letter from you probation officer addressing probationary conditions and your current status
- If your license in health care in another state has been revoked, suspended, limited or disciplined in any way, an official copy of the disciplinary action, including charges and disposition

	Are you licensed or certified in another state? **Answer Yes or No**		
	If yes, list states:		
	Has any action ever been taken against your license/certificate or is there any pending disciplinary action? **Answer Yes or No**		
	If yes, state date, type of action, and name and address of entity taking such action		
	Action	Date of Action	Entity Taking Action

Attestation by the applicant:

1	Have you practiced in Nebraska prior to the application for a license? **Answer Yes or No**	
2	If yes, what are the actual number of days you practiced in Nebraska prior to licensure?	

REGISTRATION FEE: $11.00

SECTION B - **Area of Registration**: (All applicants must complete this section.)			
☐	Audiology	☐	Speech-Language Pathology

SECTION C - **Education** - All applicants must submit a verified copy of their high school diploma or GED certificate.

SECTION D - **Training** - All applicants must have supervisor complete and submit the **Affidavit of Completion of Initial Training**, and, when applicable, the **Affidavit of Completion of Additional Training** to the Credentialing Division.

SECTION E - **Supervision** - A communication assistant must be supervised by licensed audiologist(s) or speech-language pathologist(s).

Has audiologist or speech-language pathologist submitted an application for certification of supervision? **Answer Yes or No**	
If yes, name of supervising audiologist or speech-language pathologist:	
If no, will an application for certification of supervision be forthcoming? **Answer Yes or No**	
Comments:	

SECTION H – Certification of Applicant

CERTIFICATION

I hereby certify that the preceding information is correct to the best of my knowledge and I further certify that I am of good moral character.

_____

Signature of applicant **Date**

ATTACHMENT C1

(TO BE COMPLETED BY SUPERVISING AUDIOLOGIST OR SPEECH-LANGUAGE PATHOLOGIST)

AFFIDAVIT FOR COMPLETION OF
INITIAL TRAINING FOR COMMUNICATION ASSISTANTS

I, _____, do hereby attest
(Licensed Audiologist or Speech-Language Pathologist)

that _____ has satisfactorily
(Communication Assistant)

completed at least twelve (12) hours initial training including instruction in the following areas:

1. An overview of speech and language and the practice of audiology and speech-language pathology	❑ Yes ❑ No
2. Ethical and legal responsibilities	❑ Yes ❑ No
3. Normal language, speech, and hearing functions	❑ Yes ❑ No
4. Observing and recording patient progress	❑ Yes ❑ No
5. Behavior management and modification	❑ Yes ❑ No
6. Record keeping	❑ Yes ❑ No

Date: _____ _____
Signature of Affiant
(Licensed Audiologist or Speech-Language Pathologist)

FORWARD THIS COMPLETED FORM TO

Nebraska Department of Health and Human Services
Regulation and Licensure
Credentialing Division
Audiology and Speech-Language Pathology
P.O. Box 94986
Lincoln, NE 68509-4986

ATTACHMENT C2

(TO BE COMPLETED BY SUPERVISING AUDIOLOGIST OR SPEECH-LANGUAGE PATHOLOGIST IF ADDITIONAL TRAINING HAS BEEN PROVIDED)

AFFIDAVIT FOR COMPLETION OF ADDITIONAL TRAINING FOR COMMUNICATION ASSISTANTS

I, _____ do hereby attest
(Licensed Audiologist or Speech-Language Pathologist)

that _____ has satisfactorily
(Communication Assistant)

completed additional training to provide aural rehabilitation in the following areas:

1. Information concerning the nature of hearing loss; ❑ Yes ❑ No

2. Purposes and principles of auditory and visual training; ❑ Yes ❑ No

3. Maintenance and use of amplification devices; ❑ Yes ❑ No

4. Routine cleaning of devices; ❑ Yes ❑ No

5. Other subjects:

_____ ❑ Yes ❑ No

_____ ❑ Yes ❑ No

_____ ❑ Yes ❑ No

Date: _____ _____.
Signature of Affiant
(Licensed Audiologist or Speech-Language Pathologist)

FORWARD THIS COMPLETED FORM TO:

Nebraska Department of Health and Human Services
Regulation and Licensure
Credentialing Division
Audiology and Speech Language Pathology
P.O. Box 94986
Lincoln, NE 68509-4986

Attachment D

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE
CREDENTIALING DIVISION
P.O. Box 94986
Lincoln, Nebraska 68509-4986

APPLICATION FOR CERTIFICATION OF SUPERVISION OF A COMMUNICATION ASSISTANT

(This application must be completed by the supervising audiologist(s) or speech-language pathologist(s))

SECTION A - Name of Communication Assistant	
Name:	

SECTION B - Supervising Audiologist(s) or Speech-Language Pathologist(s) Information				
1	Name:			
2	Present Address:	Street/PO/Route:		
		City:	State:	Zip:
3	NEBRASKA LICENSE NO.:	Audiologist:	Speech-Language Pathologist:	
4	Area in which the Communication Assistant is registered:			
	❑ Audiologist		❑ Speech-Language Pathologist	
1	Name:			
2	Present Address:	Street/PO/Route:		
		City:	State:	Zip:
3	NEBRASKA LICENSE NO.:	Audiologist:	Speech-Language Pathologist:	
4	Area in which the Communication Assistant is registered:			
	❑ Audiologist		❑ Speech-Language Pathologist	
1	Name:			
2	Present Address:	Street/PO/Route:		
		City:	State:	Zip:
3	NEBRASKA LICENSE NO.:	Audiologist:	Speech-Language Pathologist:	
4	Area in which the Communication Assistant is registered:			
	❑ Audiologist		❑ Speech-Language Pathologist	

SECTION C - **Practice Site(s)**			
Location(s) where communication assistant will be working:			
Facility Name			
Street Address:			
	City:	State:	Zip:
Telephone – Optional:			
Facility Name			
Street Address:			
	City:	State:	Zip:
Telephone – Optional:			

SECTION D - **Usage Plan** - All applicants must complete **The Communication Assistant Usage Plan**. Indicate which of the following duties the Communication Assistant will perform and write in the corresponding method of supervision which will be used. Examples of methods of supervision could include videotapes, direct onsite supervision, and review of records, etc.

DUTIES:	**METHOD OF SUPERVISION**	
❑	(1) Implement programs and procedures designed by licensed audiologist(s) or speech-language pathologist(s) which develop or refine receptive and expressive verbal and non-verbal communication skills.	
❑	(2) Maintain records of implemented procedures which document a patient's responses to treatment.	
❑	(3) Provide input for interdisciplinary treatment planning, inservice training and other activities directed by licensed audiologist(s) or speech-language pathologist(s).	
❑	(4) Prepare instructional material to facilitate program implementation as directed by licensed audiologist(s) or speech-language pathologist(s).	
❑	(5) Recommend speech, language, and hearing referrals for evaluation by licensed audiologist(s) or speech-language pathologist(s).	
❑	(6) Follow plans developed by licensed audiologist(s) or speech-language pathologist(s) that provide specific sequences of treatments to individuals with communicative disorders.	
❑	(7) Chart or log patient responses to the treatment plan.	
❑	(8) Provide aural rehabilitation.	

SECTION E – AFFIDAVIT

We, the undersigned, certify that we are the persons referred to in this application and that the statements herein are true and complete. We further certify that the communication assistant named in this application will not perform the functions listed in Neb. Rev. Stat. 71-1,195.07 and will not perform aural rehabilitation unless he or she has the additional training required by Neb. Rev. Stat. 71-1,195.05. We also certify that we will be responsible for supervising said communication assistant and be responsible for all aspects of patient treatment by said assistant if we are granted approval to supervise said assistant.

_____ _____.

(Date) (Signature of Supervisor)

_____ _____.

(Date) (Signature of Supervisor)

_____ _____.

(Date) (Signature of Supervisor)

(**To be completed by the supervising audiologist or speech-language pathologist if additional training has been provided)**